Abstract AB1081 Table 2. characteristics of SAPHO syndrome and AS patients with spinal involvement

characteristics	SAPHO (n=34)	AS (n=50)	P value
Sex, female	21(61.8%)	17(34.0%)	0.012*
Age at onset, yrs	52.2±10.3	35.4±12.0	0.0008*
Disease duration, yrs	6.1±7.1	7.4±7.3	NS
CRP elevated	16(46.12.1)	26 (2.11 ±2.52)	NS
ESR elevated	16 (31.2±24.0)	18 (28.4 ±24.6)	NS
HLA-B27 positive	1(2.9%)	48(96.0%)	0.000*
Cervical vertebra	17(50.0%)	13(26.0%)	0.024*
Thoracic vertebra	22(64.7%)	33(66.0%)	NS
Lumbar vertebra	17(50%)	34(68.0%)	NS
Contiguous/multiple vertebra involvement	28(82.4%)	50(100%)	0.002*
Vertebral inflammation	34(100%)	48(96.0%)	NS
Endplate inflammation	8(23.5%)	3(6.0%)	0.019*
Spondylodiscitis	16(47.1%)	4(8.0%)	0.001*
Vertebral body corner involvement	11(32.4%)	13(26.0%)	NS
Paravertebral ossification	4(11.8%)	5(10.0%)	NS

All the SAPHO patients with spinal involvement were followed up. 30 patients received NSAIDs plus DMARDS/biologics and the symptoms improved. Reexamined imaging data of 10 patients were available and the spinal involvement became better.

Conclusion: 73.9% of SAPHO patients had spinal involvement and they were more likely to suffer from cervical spine involvement, endplate inflammation and spondylodiscitis. The combination of NSAIDs and biologics/DMARDS were helpful to improve the symptoms.

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AB1082 IATROGENIC INFECTIOUS SPONDYLODISCITIS: 6 CASES

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Background: The increasing proportion of iatrogenic spondylodiscitis (SD) is a prominent feature of infectious DS in recent decades

Objectives: To describe iatrogenic clinical, aetiological and evolutive SD features.

Methods: We report 6 cases of iatrogenic DS collected in our department in 2001-2012 period.

Results: All patients were male. The average age was of 49 (35 to 68 years). Four cases of SD were caused by direct inoculation (surgical in 3 cases, chemonucleolysis in 1 case) and 2 cases of hematogenous SD from an initial outbreak. The seat of infection is lumbar in all cases. Spinal pain is almost constant. The admission examination noted apyrexia in 5 cases. A biological inflammatory syndrome was present in 5 cases and hyperleucocytosis in 2 cases. The bacteriological investigation was able to isolate a methicillin-sensitive *Staphylococcus aureus* (SAMS) and a *proteus mirabilis* in one patient and SAMS in another. The radiological assessment made it possible to objectify a para vertebral abscess in 5 cases and an epiduralitis in 1 case. The evolution was favorable in all cases under antibiotherapy of average duration of 4.5 months and immobilization of the spine by corset.

Conclusion: The detection of an anaerobic germ causing infectious spondylodiscitis should search for an iatrogenic portal chronologically and anatomically close to the vertebral disc infection.

Disclosure of Interests: None declared

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AB1083

IN A FAMILIAL MEDITERRANEAN FEVER PREVALENT REGION, ARE FAMILIAL MEDITERRANEAN FEVER AND BEHÇET'S DISEASE ASSOCIATED?

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Background: The co-existence of Familial Mediterranean Fever (FMF) and Behçet's Disease (BD) has been questioned. There have been a variety of claims on a common pathogenesis.

Objectives: We intended to report the prevalence of Familial Mediterranean Fever (FMF) and Behçet's disease (BD) and comorbidity ratio of these two diseases in Sivas, Turkey, a city where FMF is known to be very high.

Methods: Seventy-two primary schools in the center of Sivas participated in the study. A total of 14881 randomized sample children from 6th, 7th, and 8th grades, and also 985 of them with their parents (n: 978) were interviewed. During these interviews, the family tree up to second degree relatives was drawn. The presence of a diagnosis of FMF or BD was questioned. The ones who have a diagnosis were confirmed by contacting the medical centers. The ones who were suspected of a disease were further investigated at Sivas Cumhuriyet University Medical Faculty, Family Medicine Outpatient unit. For each disease a disease related history, physical examination, eye examination and patchy test for BD were performed when needed.

Results: 985 students, 978 mothers, 953 fathers and 1876 relatives (4792 in total) were included in the study. Only 30 (0.6%) of the sample was diagnosed with FMF, and 3 (%0.06) was diagnosed with BD. One of them had concomitant FMF diagnosis.

Table. FMF symptoms within the last year

Symptoms	N	%
Abdominal Pain	20	66.7
Fever	23	76.7
Joint Pain	8	26.7
Chest Pain	10	33.3
Muscle Pain	7	23.3
Erysipelas like erythema	5	16.7

Conclusion: The prevalence of FMF in Sivas is higher than Turkey's prevalence; however, BD prevalence was found very low. According to these findings, it is not easy to conclude that these two diseases share a similar background of pathogenesis.

Disclosure of Interests: None declared

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AB1084

PECULIARITIES OF ERYTHEMA NODOSUM ASSOCIATED WITH SARCOIDOSIS AND BACTERIAL-VIRAL INFECTION IN RHEUMATOLOGIST PRACTICE

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Background: Erythema nodosum (EN) is a nonspecific immune inflammatory syndrome, which is a septal panniculitis without vasculitis. Often EN acts as one of the symptoms of systemic pathology, which can cause late diagnosis and, accordingly, the appointment of adequate therapy.

Objectives: to study clinical, laboratory and radiological data in EN in the acute form of sarcoidosis (SAR) and EN associated with bacterial and viral infection in patients sent to the rheumatology center.

Methods: The study included 312 patients (61 men and 251 women, age 35.4 ± 8.2 years) who applied to the clinic with a referral diagnosis of EN in 2007-2017. The median duration of the disease was 1.6 [0.3;4.7] months. All patients underwent a comprehensive clinical examination and laboratory and instrumental examination of biochemical, serological (ASL-O, antibodies against chlamydia and Mycoplasma of 2 classes, ureaplasmas, herpes viruses of type I and II, cytomegalovirus, Epstein-Barr virus, hepatitis B/C, Yersinia, HIV, etc.) and immunological parameters, radiography or computed tomography (CT) of the chest organs.